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Epic Failure of Ebola and Global Health Security

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AFTER CAPTURING HEADLINES AND TRIGGERING controversies in 2014, the outbreak of Ebola virus disease in West Africa appears—as of early 2015—to be waning in the most affected countries.¹ The turnaround from the darkest moments of 2014 to the improving reports from Guinea, Liberia, and Sierra Leone in early 2015 is attributed to increased national and international responses, illustrated by *Time* magazine's decision to name "Ebola fighters" as its Person of the Year for 2014.² Although the worst is perhaps over, the improving situation cannot hide the public health, governance, and political failures that occurred during the epidemic. The failures are epic because actions taken nationally and internationally deviated from the strategy that the international community designed, built, and implemented over 20 years to manage threats to global health security. The behavior of states and international organizations damaged virtually every element of this strategy and revealed how fragile progress has been since global health security emerged as a policy objective in the latter half of the 1990s.

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The process of conducting forensics on the Ebola tragedy is underway. International health reform ideas and proposals, such as creating a global public

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health reserve workforce, have been proffered by actors including the World Health Organization (WHO). Whether these efforts can trigger another political transformation in global health, to match the one that produced the strategy for global health security, remains to be seen—but early indicators, such as uncertain prospects for major increases in global health spending, are not promising. International politics—both specific to global health and more generally—do not appear conducive to sustaining the reforms that the Ebola outbreak has demonstrated are needed. These reforms would ask states to accomplish political, institutional, and legal objectives that they have never accepted, even after outbreaks potentially more dangerous than Ebola. In short, the failures of the Ebola response may not produce the changes necessary to sustain global health security as a strategic priority in global politics.

EXPLAINING THE EBOLA OUTBREAK

Although first identified in Africa in 1976, the Ebola virus only became widely known through books published in the first half of the 1990s, including Richard Preston's *The Hot Zone* and Laurie Garrett's *The Coming Plague*.³ However, the frightening nature of the virus communicated in these books did not tell the full story. Until the 2014 outbreak, experts handled Ebola episodes in Africa in ways that limited their health impact and geographical footprint.⁴ Many earlier, smaller Ebola outbreaks occurred before infectious diseases became a more salient national security, foreign policy, and international relations issue in the late 1990s and in the early twenty-first century. The fact that the biggest Ebola outbreak in history, which occurred after global health, became so important in international politics requires explanation.

The Ebola virus that ripped through West Africa in 2014 was not an unknown strain, so the outbreak was not a “viral surprise,” like the first-recorded emergence in human populations of the coronavirus behind the Severe Acute Respiratory Syndrome (SARS) pandemic in 2003.⁵ Unlike previous Ebola outbreaks, the one in 2014 occurred in West Africa as opposed to Central Africa, and in urban environments as well as rural settings. However, in 2014, neither the potential for transboundary virus migration nor the disease dangers associated with urbanization in developing countries was a new concept. Analyses of emerging and reemerging infectious diseases had identified these factors since the early 1990s.⁶ Thus, the outbreak was not impossible or improbable in epidemiological or public health terms—which makes the subsequent failures to respond adequately all the more disconcerting.

The West African countries most affected by the outbreak are developing countries emerging from civil wars that devastated governmental capacity in many sectors, including health care. For years, Guinea, Liberia, and Sierra Leone have been on the agenda of the UN's Peacebuilding Commission, which was established in 2005 to help post-conflict nations by coordinating assistance, raising resources, and providing advice on peacebuilding strategies.⁷ The lack of health-sector capacity, including inadequate medical facilities and insufficient numbers of health care personnel, became a frequent explanation for the Ebola outbreak's severity.⁸ The impact of armed conflicts on the ability of societies to address infectious diseases had long been identified as a risk factor.⁹ The need for national capacities to identify and respond to health threats became a central aspect of the global health security strategy. This imperative became the source of binding international legal obligations years before the Ebola outbreak, which makes the lack of such capacities in the three most affected countries an indicator of strategic failure.

Put differently, what happened was anticipated: a dangerous virus spreads across borders and thrives in urban and rural environments in developing countries that lack health-sector capacities and struggle with the pathologies that afflict post-conflict societies. The outbreak was not a global health riddle wrapped in a mystery inside an enigma. It was an epidemiological probability wrapped in public health expectations inside a purpose-built governance strategy. Yet, tragedy ensued, measured by the dead, the infected, the stigmatized, and the social and economic costs rippling through societies least able to bear setbacks to their development.

In this case, the probable became the actual, and the expected became the epidemic—leaving what happened in the political and governance realms as key factors in explaining what went wrong. Criticisms have concentrated on the failures of leaders and institutions, with WHO and its officials receiving harsh rebukes. However, despite the massive failure of WHO, the political and governance problems exposed by the Ebola outbreak cannot all be laid at the feet of WHO Director-General, Margaret Chan, and the organization she leads.

THE GLOBAL HEALTH SECURITY STRATEGY

From 1995 until WHO's adoption of the revised International Health Regulations (IHR) in 2005, governments, WHO, and non-state actors built a new approach to infectious disease threats that linked public health and security thinking, generally under the moniker "global health security."¹⁰ This strategy

broke new ground and featured prominently in the political revolution global health experienced in that decade.¹¹ This revolution involved, among other things, the rise of infectious diseases as a national security and foreign policy issue for states—which changed how countries, individually and collectively, approached infectious disease challenges. Understanding these changes is important to comprehending the scale of the political, institutional, and legal failures associated with the Ebola outbreak.

FROM HEALTH FOR ALL TO GLOBAL HEALTH SECURITY

Prior to the emergence of global health security, the best known international health strategy was WHO's Health for All approach launched in the late 1970s.¹² Health for All sought to advance the human right to health found in WHO's constitution and human rights treaties, such as the International Covenant on Economic, Social, and Cultural Rights.¹³ The strategy advocated access to primary health care and highlighted an array of health problems endured by people in developing countries. Health for All's focus on human rights and developing country needs contrasted with the narrow, largely trade-based infectious disease regime that WHO inherited from pre-World War II international health cooperation.¹⁴ WHO incorporated this regime as the International Sanitary Regulations in 1952 and renamed it the International Health Regulations in 1969. This regime focused on a small number of quarantinable diseases (such as cholera, plague, yellow fever, and smallpox), the management of which had potential adverse consequences for international trade and travel.

By the time Health for All emerged, experts considered the IHR ineffective and irrelevant because countries violated the rules regularly and because the regulations applied to only a few diseases.¹⁵ Unlike Health for All, the IHR was not based on a human rights framework and did not emphasize the needs of poor nations, which explains why developing countries did not consider the regulations a priority. Developed states had domestic capabilities to handle the diseases the IHR covered, which rendered the regime insignificant for these states.

When the global crisis of emerging and reemerging infectious diseases was identified in the first half of the 1990s, Health for All was a failed endeavor because it never gained serious political traction with most states, even if it remained morally potent among persons working in international health.¹⁶ Instead of relying on human rights and privileging health concerns in poor countries, the new approach to mounting infectious disease threats appealed to the national security, economic, and foreign policy interests of nations, including powerful

states. In crafting the global health security strategy, governments, WHO, and non state actors broke from the rights-based, Health for All ethos to chart a new political direction grounded in the core self-interests of states.

COMPONENTS OF THE STRATEGY

The main proposition of the global health security strategy was that countries, strong and weak, could not protect their security, political, and economic interests from serious disease threats without new forms of international cooperation, institutional capabilities, and legal obligations. Linking health threats with these interests had consequences beyond WHO. Nonetheless, the global health security idea became associated with WHO's efforts to strengthen its surveillance and response capabilities and to revise the IHR in order to transform how countries managed the globalization of infectious diseases.¹⁷

This shift in policy, however, required crises before the new strategy could gain traction. The anthrax attacks in the United States in October 2001 solidified the political argument that public health was a national and international security issue. These attacks prompted the United States to undertake domestic efforts to protect against bioterrorism and naturally occurring infectious diseases and to launch a Global Health Security Initiative in 2001 among the G7 countries and Mexico.¹⁸ In 2003, SARS alerted countries to their vulnerabilities to cross-border disease spread and catalyzed the completion of the revised IHR in 2005.¹⁹

The global health security concept, and the revised IHR it inspired, holds that infectious disease threats should be on the agendas of political, economic, and diplomatic leaders—not just health officials. Previously, international health did not feature prominently in national security, economic policy, and foreign affairs, meaning that health did not factor into the high politics of international relations. Rather, health was considered a humanitarian problem that fell low on the list of priorities

for most countries. Such marginalization helps explain why Health for All, with its human rights and developing country emphases, never had the impact its champions sought. The global health security approach, channeled in part through the revised IHR, aimed to ensure that prevention of, protection against, and responses to infectious diseases connected to key self-interests of all states.

Achieving this goal required changes in international cooperation, especially

The global health security concept holds that infectious disease threats should be on the agenda of political and economic leaders—not just health officials.

with respect to international law and WHO's responsibilities. In international legal terms, the old IHR covered only a small number of diseases, was sensitive to state sovereignty, and was not demanding in terms of public health. By contrast, the revised IHR applies to a range of known threats as well as to unknown pathogens that might emerge. The revised IHR requires WHO member states to notify WHO of any disease event that might be a "public health emergency of international concern."²⁰ The new IHR also empowers WHO to receive and use information from non state actors, such as nongovernmental organizations—a shift that demonstrates skepticism toward government-provided data, as well as the desire to exploit new communication technologies to achieve faster, more comprehensive sharing of disease information.²¹ Supporting these provisions is the requirements that all WHO member states develop core national surveillance and response capacities, such as the abilities to detect unusual disease events, report information to guide responses, and identify measures to prevent disease spread. These obligations are unprecedented in the history of international health cooperation, which emphasize epidemiology over sovereignty in the pursuit of global health security.²²

The revised IHR also reflects global health security's emphasis on robust institutional capability in how the regulations make WHO central to managing international disease threats. The revised IHR gives WHO leadership roles in conducting surveillance, undertaking epidemiological and scientific analysis, providing scientifically grounded advice on responding to outbreaks, and deciding when an event constitutes a public health emergency of international concern.²³ The leadership that WHO demonstrated under Director-General Gro Brundtland during the SARS epidemic informed how the revised IHR empowers WHO institutionally as part of the global health security strategy.

In keeping with its political framing, the global health security strategy seeks to balance justified responses to disease threats with other political interests and values, particularly trade and human rights. The revised IHR requires public health measures to be the least trade restrictive and the least intrusive of human rights while achieving effective surveillance and response.²⁴ The key metric in achieving this balance is the scientific and public health necessity of measures taken. This emphasis privileges epidemiology over sovereignty, places serious demands on governments, and underscores WHO's central role in providing scientifically informed recommendations.²⁵

IMPLEMENTING THE STRATEGY

The global health security strategy experienced problems after the adoption of the new IHR, but it proved more effective than both the old IHR and other previous approaches, especially in terms of information sharing. Although, the WHO-led response to SARS occurred before finalization of the revised IHR, the response rolled out approaches that WHO was considering in the revision process.²⁶ The

perceived effectiveness of these approaches produced rapid agreement among WHO member states on the revised IHR in 2005, making SARS a successful proof of concept for the improved regulations and a stronger role for WHO. The influenza A (H1N1) pandemic in 2009 constituted the first real test of the new IHR, including the first time WHO's Director-General declared a public health emergency of international concern.²⁷ Despite the problems and controversies explained below, the general perception was that the IHR functioned satisfactorily during this event.

However, the global health security strategy and revised IHR have encountered difficulties. Questions arose about IHR compliance by WHO member states during the H1N1 outbreak and the emergence of the Middle East Respiratory Syndrome (MERS), particularly concerning the requirement to develop national surveillance and response capacities. During the H1N1 pandemic, experts criticized some trade and travel measures—such as bans on pork imports and quarantine of travelers—because they were not based on science and public health principles, and thus unnecessarily infringed on trade and human rights.²⁸ Concerning MERS, health officials grew frustrated with the inadequate sharing of information on the part of Saudi Arabia.²⁹ The 2012 deadline for countries to meet IHR national capacity requirements passed with the vast majority of states failing to comply.³⁰

In addition, controversies erupted that fell outside the IHR but raised tough questions about the global health security strategy. In 2007, amid fears that bird flu could mutate into a pandemic, Indonesia withheld samples of the avian influenza A (H5N1) virus from WHO.³¹ Indonesia was protesting the way that WHO handled influenza virus samples shared by countries, as well as the lack of equitable developing-country access to the benefits of vaccine research and development undertaken with these samples. WHO argued that the IHR

The 2012 deadline for countries to meet IHR national capacity requirements passed with the vast majority of states failing to comply.

required Indonesia to share samples, but the regulations do not contain this requirement, meaning WHO's effort to apply the IHR failed. Instead, WHO-sponsored negotiations on the influenza virus and benefit sharing produced the nonbinding Pandemic Influenza Preparedness (PIP) Framework in 2011.³² This episode revealed a global health security concern of developing countries—access to influenza vaccines—that the IHR did not regulate and that required additional diplomacy to address.

Similarly, the H1N1 pandemic triggered acrimony about equitable vaccine access when, in the early stages of the outbreak, developed countries secured access to most of the vaccine supply.³³ Again, the IHR does not regulate vaccine access, and in 2009, the PIP Framework had not yet been adopted. However, from the perspective of developing countries, the lack of equitable access to vaccines undermined their health security and placed additional stress on the political fault-line, exposed by the H5N1 virus/benefit-sharing controversy between developed and developing countries. Some critics also accused WHO of conspiring with vaccine and antiviral manufacturers to boost their profits by using its IHR authority to push governments to buy H1N1 products.³⁴

In what amounted to an analysis of the global health security approach, the IHR Review Committee assessed the IHR's functioning during the H1N1 outbreak. The Review Committee concluded in 2011 that the "IHR helped make the world better prepared to cope with public-health emergencies" and that "WHO performed well in many ways during the pandemic."³⁵ It found no "direct evidence of commercial influence on [WHO's] decision-making."³⁶ However, the Review Committee argued that the "world is ill-prepared to respond to a severe influenza pandemic or any similarly global, sustained, and threatening public-health emergency."³⁷ It recommended, among other things:

- Accelerating efforts to help countries develop core surveillance and response capacities;
- Strengthening WHO's capabilities to address serious infectious disease events;
- Establishing a "global, public-health reserve workforce" to support responses to health emergencies;
- Creating "a contingency fund for public-health emergencies" to support the "surge capacity" needed to address such emergencies.³⁸

In short, the Review Committee highlighted progress and problems with the global health security strategy as embodied in the IHR and WHO after the

H1N1 crisis. Even considering the challenges the Review Committee identified, few would have believed that within three years, the political, institutional, and legal pillars of this strategy would be shredded by an outbreak of Ebola in Africa.

THE EPIC FAILURE DURING EBOLA

Simply put, the Ebola outbreak constitutes a comprehensive public health, political, and governance failure for WHO, the IHR, and the global health security strategy. Professor Lawrence Gostin, one of the world's leading experts on global health governance, noted that "the groundswell of dissatisfaction and lack of trust in WHO over Ebola has reached such a crescendo that [without] fundamental reform . . . we might lose confidence in WHO for a generation."³⁹ Many countries violated the IHR by responding to the outbreak with measures, such as bans on travel to and from West Africa, supported by neither science nor public health. The lack of health capacities in Guinea, Liberia, and Sierra Leone exposed during the Ebola outbreak made large-scale noncompliance with the IHR's obligations on national surveillance and response capacities even more embarrassing. The outbreak also exposed to criticism WHO's pre-Ebola decision to reduce its institutional capabilities most relevant to responding to a serious disease outbreak.

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WHO AND THE EBOLA OUTBREAK

The magnitude of WHO's failure is hard to exaggerate. Efforts to defend the organization collapsed under an unprecedented torrent of criticism, and then gave way to admissions by WHO officials that the organization had made many mistakes. As described above, the global health security strategy gives WHO the central global leadership role in addressing serious disease threats. The Ebola outbreak revealed that WHO was neither willing nor able to play this role. This abdication of responsibility happened through political and governance decisions made before and during the Ebola crisis.

WHO did nothing with the Review Committee's recommendations that emerged from the H1N1 pandemic, even as the organization undertook a high-profile institutional reform process after that episode. Commentators jumped on this omission when Ebola began to rage through West Africa. With no surge capacity, contingency fund, or leadership from the Director-General, WHO lost its leading role to the UN and developed countries. Nor did WHO's reform process—which began in 2010—address long-standing problems such as the

harmful politicization of public health activities that the organization experiences in its regional and country offices. WHO and external critics identified how WHO's regional office in Africa, as well as country offices in the most affected countries, contributed to the Ebola outbreak's severity through incompetence, failure to send reports on Ebola to WHO's headquarters, denying visas to Ebola experts, and blocking distribution of aid.⁴⁰

Perhaps worse—and flying in the face of the global health security strategy and the Review Committee's recommendations to strengthen WHO's capabilities—WHO cut the budget and staff allocated to outbreak surveillance and

In the eyes of many, WHO lacked the capabilities to mount effective responses to the Ebola outbreak.

response as part of a strategic decision to address fiscal problems and give more priority to other issues, such as noncommunicable diseases (NCDs) and

universal health coverage (UHC).⁴¹ WHO went in this direction despite experts' recommendations that the organization deepen its commitment to global health security in its reform process.⁴² As the virus wreaked havoc across West Africa, many agreed with the argument that "WHO was MIA [missing in action] during the early months of the outbreak" because it "gutted its emergency response and surveillance unit."⁴³

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These pre-Ebola acts and omissions reveal weak political support for the global health security strategy within WHO prior to the outbreak. The failure to take up the Review Committee's recommendations, the decision to decrease funding and staffing for surveillance and response activities, and the desire to focus more attention and resources on issues outside global health security suggest complacency, ambivalence, disinterest, and/or animosity about the global health security strategy among WHO officials and member states. In global health security terms, WHO ignored the problems identified by the Review Committee and undercut the progress that the Committee highlighted. Perhaps these political headwinds in WHO informed the U.S. launch in February 2014 (the month before initial Ebola reports emerged from West Africa) of its Global Health Security Agenda as a way to heighten diplomatic attention to global health security.⁴⁴

WHO's performance during the outbreak reinforces what one would expect from its pre-Ebola behavior. In the eyes of many, WHO responded too slowly to the outbreak, lacked the capabilities to mount effective responses once it understood the scale of the problem, and lost credibility as a global health leader within and beyond the UN. Even taking into account the complexi-

ties of the outbreak's emergence and evolution, internal and external critiques delivered harsh verdicts on WHO's handling of this emergency.⁴⁵ Attempts to argue that the outbreak surprised the global health community in ways that could not be foreseen became increasingly frustrating as people connected the mistakes WHO made during the crisis with the organization's pre-outbreak acts and omissions. Damningly, the outbreak exposed WHO's political neglect of global health security before the crisis, along with the institution's inability to function effectively once the crisis was underway.

THE IHR AND THE EBOLA OUTBREAK

As noted above, the IHR is the international legal centerpiece of the global health security strategy, and the IHR's travails during the Ebola outbreak form another depressing feature of the crisis. Before this outbreak, the Review Committee identified problems with the IHR that required attention. First, reflecting on trade and travel measures imposed by WHO member states during the H1N1 pandemic, the Review Committee recommended reinforcement of the following IHR requirement: that measures affecting trade and travel have scientific and public health bases. Second, the committee recommended stronger efforts, such as greater donor-country support for IHR-based capacity building, to address significant noncompliance with the IHR obligations to develop core national surveillance and response capacities.⁴⁶ The Ebola outbreak revealed that WHO had made no progress on either of these issues.

Compounding the failures concerning surveillance and response capacities, dozens of countries implemented measures in response to the Ebola crisis that neither followed WHO's recommendations nor lacked a scientific and public health justification, such as travel bans or restrictions on persons traveling from West Africa. WHO reported that "very few countries informed WHO that they were implementing additional measures significantly interfering with international traffic and when requested to justify their measures, few did so."⁴⁷ Such measures and behaviors violate the international legal obligations prescribed in the IHR. Although IHR violations occurred in previous outbreaks, such as during the H1N1 pandemic, the scale and brazenness of violations during the Ebola crisis are worrying. Ideally, violations should decrease the longer international rules are in place. However, the Ebola outbreak reflects the opposite trend, with many states failing to follow legally binding rules designed to ensure that outbreak responses do not harm trade and human rights without justification. The seriousness of what happened concerning the IHR's rules on trade

and travel measures featured in analyses of the crisis, including that by WHO's Director-General.⁴⁸

The outbreak also underscored the lack of progress in improving compliance with the IHR's obligations on national surveillance and response capacities. The poor-to-nonexistent public health and health care capacities in Guinea, Liberia, and Sierra Leone not only exacerbated the outbreak, but it also reminded people of the crisis with the IHR's capacity obligations, previously highlighted by the Review Committee and other experts. In fact, the challenge of achieving widespread compliance with these obligations, especially in developing countries, was identified when the revised IHR was adopted.⁴⁹ This problem was present at the creation of the new IHR. Yet, as evidenced by the Review Committee's report in 2011 and the Ebola episode in 2014, no serious multilateral strategy, let alone funding, to advance the level of compliance has ever been constructed and implemented after the IHR's adoption. In November 2014, the Review Committee "found that only 64 of WHO's 194 Member States had the essential surveillance, laboratory, data management, and other capacities in place to fulfill their obligations under the IHR."⁵⁰ This dismal track record suggests that, nearly a decade since the IHR's adoption, this legal element of the global health security strategy has been marginalized and neglected in global health governance and politics.

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HEALTH, SECURITY, AND POST-CONFLICT SOCIETIES: THE UN PEACEBUILDING COMMISSION AND THE EBOLA OUTBREAK

The fragile health capacities in Guinea, Liberia, and Sierra Leone cannot be blamed solely on noncompliance with the IHR or on WHO. The importance of health-sector capabilities in improving social and economic conditions has long been recognized in development policy. Despite this awareness, each of these countries faced Ebola with poor health capacities, which were overwhelmed by the virus and the damage caused to medical personnel, health facilities, economic activity, and social cohesion. Capacity had to be imported on a large scale from developed countries, producing dependence on foreign medical volunteers, public health experts, and military forces. This dependence meant the delivery of Ebola-tailored health capacity happened through some of the most unsustainable means imaginable. As Médecins Sans Frontières (MSF) argued, "it has become alarmingly evident that there is no functioning global response mechanism to a potential pandemic in countries with fragile health systems."⁵¹ This reality could not be more distant from the global health security strategy's

objective of sufficiently robust national health capacities managing disease events with supplementary assistance, as required, from the international community.

Explaining the situation in which Guinea, Liberia, and Sierra Leone found themselves when Ebola arrived in West Africa requires looking beyond the failure to comply with IHR mandates on surveillance and response capacities. As previously noted, each of these post-conflict countries

has been on the agenda of the UN Peacebuilding Commission (PBC) for years. The UN

The delivery of Ebola-tailored health capacity happened through some of the most unsustainable means imaginable.

established the PBC as part of the institutional reform that emerged from the World Summit in 2005.⁵² The PBC's mandate is to help post-conflict countries rebuild governance capabilities and economic infrastructure in order to prevent future conflict and advance peaceful human development.⁵³ Although the PBC has issued statements about the Ebola outbreak's potential "to reverse the peacebuilding gains achieved in the affected countries," it is not clear whether health-capacity problems formed part of the PBC's work with Guinea, Liberia, or Sierra Leone before the outbreak.⁵⁴ Nor is it clear whether the associated UN Peacebuilding Fund has allocated resources to strengthen health system capacities in these countries.⁵⁵ This lack of clarity raises the question—relevant to the relationship between health and security in post-conflict societies—of whether the UN's flagship entity for helping post-conflict societies has addressed health system problems in Guinea, Liberia, and Sierra Leone that proved major threats to peacebuilding efforts during the Ebola outbreak.

This question connects to concerns—as discussed above with respect to equitable access to vaccines—that the actual implementation of the global health security strategy shortchanges developing countries. The Ebola outbreak agitated these concerns in other ways, including the lack of medical products for Ebola and the lack of access in West Africa to the experimental antiviral drugs used to treat Ebola-infected persons in Europe and the United States.⁵⁶ This issue ties into long-standing controversies about inadequate levels of research and development on infectious diseases that predominantly affect developing countries.⁵⁷ These problems feed the skepticism of developing countries that suspect global health security really means health security for rich countries.

BEYOND THE EBOLA OUTBREAK: A GLOBAL HEALTH SECURITY RENAISSANCE?

The process of gathering lessons learned from the Ebola outbreak and formulating

reforms to avoid such a tragedy in the future has already begun. Most prominently, as of this writing, WHO's Executive Board adopted a resolution on 25 January 2015 in a special session on Ebola that supported far-reaching reforms for global health security.⁵⁸ Although underscoring the years wasted since the Review Committee made the same proposals, the resolution calls for a global health emergency contingency fund and a global public health reserve force to support responses to health emergencies.⁵⁹

In remarks to the Executive Board, Director-General Margaret Chan put additional, but still familiar ideas on the reform agenda that connect with problems global health security experienced before and during the Ebola outbreak.⁶⁰

However unfortunate, major policy changes often require crises to catalyze political action.

She implored countries "to turn the 2014 Ebola crisis into an opportunity to build a stronger system to defend our collective global health security." In addition

to supporting the contingency fund and reserve force proposals, Chan argued that the IHR "need more teeth" because global health security will suffer "until more countries, and eventually all countries, have core capacities in place." This goal, Chan argued, required developed countries to provide more support to countries needing help to build health systems capacities. She also emphasized "the need for new medical products . . . [because] the world must never again find itself empty-handed when a severe epidemic-prone disease strikes, especially one that has been known for nearly 40 years."⁶¹

With the reform phase still unfolding, predictions about the success or failure of proposals are foolhardy. Nevertheless, some preliminary thoughts are in order. However unfortunate, major policy changes often require crises to catalyze political action. The global health security strategy arose in response to the crisis of emerging and reemerging infectious diseases. The SARS scare solidified the strategy's political importance and made a strengthened WHO and the revised IHR key components of it. The Ebola outbreak has proved serious enough for governments, international organizations, and non state actors to identify problems, propose reforms, and pledge commitment to change. This outbreak has clearly started the next chapter for the global health security strategy in global health politics.

The nature and scale of changes contemplated in proposed reforms raise difficult challenges. Some are practical; for example, establishing, funding, and operating a contingency fund and reserve force will be complicated tasks.⁶² Other challenges are more strategic. After downgrading global health security

before the Ebola outbreak, WHO must now pivot in the opposite direction. Although the Executive Board's resolution is seminal because one of WHO's governance bodies adopted it, its proposals face difficulties from WHO's politics and bureaucracy. Shifting an international organization that so-badly failed during the Ebola outbreak to one that is able to shoulder these reforms constitutes a formidable institutional undertaking. Before Ebola, WHO was suffering from serious financial difficulties, competition from other global health actors, and a reform process criticized as superficial. After Ebola, WHO faces the challenge of engaging in serious reform from an even weaker position.

To fulfill new responsibilities in global health security, the organization must be comprehensively rejuvenated—a task that WHO member states failed to achieve in pre-Ebola reform efforts. Revitalizing WHO to manage new global health security initiatives depends on the political commitment of member states and their willingness to support the initiatives with additional resources. This requirement must involve an about-face by member states that, before Ebola, were squeezing WHO financially, marginalizing global health security in the organization's activities, not prioritizing the IHR, and demonstrating no interest in serious WHO reforms.

Avoiding political whiplash in changing directions will require ameliorating tensions between developed and developing countries. Developing countries will expect developed nations to provide the lion's share of the resources for the contingency fund, the reserve force, increased IHR compliance concerning surveillance and response capacities, and improvements in developing-country access to health technologies, such as vaccines, relevant to their health security problems. Developing countries will also expect developed states to continue to fund existing efforts (for example, HIV/AIDS, NCDs, and UHC) and provide money to addressing emerging health threats, such as those related to climate change. Although their support for global health increased significantly over the past 10 to 15 years, developed countries are not likely to act similarly in the aftermath of the Ebola crisis. If increased funding does not become available, countries will have to agree on priorities in order to allocate limited funds—a process that often reveals the extent of differences in national interests on global health, especially between developed and developing states.

A premise of the global health security strategy is that states perceive infectious diseases as a high-profile political, economic, security, and foreign policy issue. The Ebola outbreak stimulated much rhetoric about health emergencies as threats to national and international security, but we have only to recall how WHO member states marginalized the global health security strategy before

the Ebola crisis to appreciate a deeper problem. This and previous epidemics illustrate the elasticity of global health as an issue in international relations. When a crisis emerges, outbreaks often get connected to national security and foreign policy thinking, as happened when the UN Security Council declared the Ebola outbreak in West Africa a threat to international peace and security.⁶³ Once the emergency fades, the global health problem tends to fall back down the list of political priorities.


Whether an elastic or inelastic political dynamic occurs with the proposed post-Ebola reforms remains to be seen. However, in the current international political environment, these reforms might not compete effectively with other national security and foreign policy priorities—especially for countries, such as the United States, that are expected to bear most of the costs to advance global health security. Russian assertiveness, the rise of Chinese power, the dangers posed by the Islamic State, the resurgence of global terrorism, and increasing cybersecurity threats dwarf the Ebola outbreak as matters of national security and foreign policy importance for the United States and other countries.

In addition, when the United States has treated a global health problem as a serious national security and foreign policy concern, it has typically mounted its own initiatives—such as the President’s Emergency Plan for AIDS Relief—rather than relying on international organizations. In keeping with this pattern, the U.S. government ramped up its Global Health Security Agenda during the Ebola crisis.⁶⁴ How the United States maneuvers between its initiative and the reform proposals at the multinational level bears watching in the coming months. The U.S. push for its Global Health Security Agenda could help catalyze post-Ebola diplomatic activities on global health security. However, depending on what happens within WHO, tensions could arise between U.S. interests and priorities and what other countries, particularly developing ones, want in the aftermath of the Ebola tragedy.

Proposals coming in the wake of Ebola envision a formidable political, institutional, and legal reform agenda. The agenda contains tasks that states have proved incapable of undertaking in the past: making sustainable political commitments to global health security; undertaking serious reforms of WHO; adequately funding strengthened WHO capabilities; providing sufficient assistance to enable developing countries to build public health capacities; and accepting enforceable rules of international health law. States have failed to do these things no matter what disease most recently became an epidemic—which raises the question of whether the Ebola outbreak has the potential to break this long-standing pattern of behavior. The waning of the Ebola crisis in early

2015 has prompted warnings from global health experts that political attention is already weakening—putting in jeopardy not only the objective of eliminating all Ebola cases from West Africa, but also the political, institutional, and legal reforms needed to repair global health security.

CONCLUSION

Like SARS, the Ebola outbreak in West Africa constitutes a historic inflection point for global health security. However, as inflection points, the two differ in ways that magnify the challenges facing the post-Ebola outbreak world. SARS was a triumph of WHO leadership and skill and catalyzed advances in global health security, especially the revised IHR. The Ebola outbreak has been a failure of epic proportions for WHO, the IHR, and the global health security strategy. Changes made after SARS rode the unprecedented wave of political attention that global health received in the first decade of the twenty-first century. Changes after the Ebola outbreak have no such wave to ride and will have to navigate a much more difficult international political environment. The transformation of the global health security strategy after SARS helped prepare the world for future outbreaks that experts knew would come. However difficult they might be to achieve, transformations after the Ebola outbreak are likewise necessary to ensure that epidemiological probabilities wrapped in public health expectations fall inside a more effective governance strategy for global health security. 

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